

Member Personal Health History Form

Fitness Source

320 E. 12th Street, Kansas City, MO 64106 Phone: 816.513.1382 Fax: 816.513.1383

Name: _____ Day Time Phone: _____

D.O.B. _____ Age: _____ Height: _____ Weight: _____

I understand that the following information will be kept confidential. I also understand that data obtained may be used for statistical purposes reported in aggregate form with my right to privacy retained. My responses to the following questions may be shared with my physician and may require medical clearance before I can participate in an exercise program.

Check the following statements that are TRUE for you.

- ☐ You have had any of the following: a heart attack, heart surgery, heart failure, heart valve disease, heart transplantation, cardiac catheterization, coronary angioplasty or pacemaker/defibrillator.
- ☐ You experience chest discomfort with exertion.
- ☐ You experience abnormal shortness of breath at rest or with mild exertion.
- ☐ You experience dizziness, blackouts or fainting.
- ☐ You take heart medications.
- ☐ You have diabetes or any other metabolic disease.
- ☐ You have asthma or any other pulmonary disease.
- ☐ You have burning or cramping in you lower legs when walking short distances.
- ☐ You have muscular or skeletal problems that limit your physical activity.
- ☐ You are currently pregnant.

(PR for ≥ 1)

- ☐ You are a man 45 years or older.
- ☐ You are a woman 55 years or older and/or have had a hysterectomy or are postmenopausal.
- ☐ You smoke or have quit within the previous 6 months.
- ☐ You have high blood pressure, are being treated for high blood pressure **or** you do not know your blood pressure.
- ☐ You have high cholesterol, are being treated for high cholesterol **or** you do not know your cholesterol level.
- ☐ You are pre-diabetic (fasting glucose $\geq 100\text{mg/dL}$).
- ☐ You do not know your fasting glucose level **and** you are over 45 years of age **or** are more than 20 pounds overweight.
- ☐ You have anyone in your immediate family (father, mother, sister or brother) who had a heart attack, heart surgery or died suddenly before age 55, father or brother, or age 65, mother or sister?
- ☐ You are more than 20 pounds overweight.
- ☐ You get less than 30 minutes of physical activity on at least 3 days per week (sedentary lifestyle).

(PR for ≥ 2)

1. Personal Physician: _____ Phone: _____ Fax: _____

2. Specialists (i.e. cardiologist): _____ Phone: _____ Fax: _____

3. When was the last time you had a complete physical exam? Date: _____

4. Do you have a history of any of the following, if so please explain:

- Neck/Back Pain _____
- Physical/Athletic Injury _____
- Muscle/Joint Injury _____

5. Have you had any operations or surgeries in the past six months, if so please explain:

6. Do you currently exercise? Yes No

7. If yes, what do you do for exercise? _____

8. List any medications you are currently taking:

Medication

Purpose

Medication	Purpose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

9. Is there anything else about your medical history that we should know before you begin an exercise program?

To the best of my knowledge I have completed this form honestly & completely. I understand that it is my responsibility to inform this fitness facility of any changes in my health status that may affect my participation in exercise activities.

If I answered yes to any of the questions on this form that require a physician's release, I give consent for Fitness Source to share this information with my physician.

Signed: _____ Date: _____

Staff Use Only:

Cleared to Exercise _____ Not cleared to Exercise _____ Reason: _____

Number of Risk Factors Questions 1 – 10: _____

Number of Signs / Symptoms Questions 11 – 20: _____

Age: _____

Physicians Release Requested: YES or NO

Date Sent: _____ / _____ / _____

Staff Signature: _____